This form is intended to be printed, completed and mailed through the U.S. Postal Service. Forms or replications of forms returned by e-mail will not be accepted for processing.

Board of Industrial Insurance Appeals
PO Box 42401 Olympia, WA 98504-2401

NOTICE OF APPEAL

Public Disclosure-Please note that information provided may be subject to pubic disclosure under RCW 42.56

If you disagree with a decision of the Department of Labor and Industries concerning a workers compensation claim, this form can be used to file an appeal of that decision. You must file the appeal with the Board of Industrial Insurance Appeals, **WITHIN 60 DAYS of the date you received** the Department s decision. The appeal can be filed with the Board personally or by mail at the above address.

***indicates required information.**

Today's date:_____: Appeal filed by __Claimant __Beneficiary __Claimant's Physician __Employer

Claimant's Name* _____ _____ L&I Claim No*: _____

Date of L&I Decision*: _____ [copy attached]

Date of Injury/Occupational Disease: _____. City where injury/Occupational Disease occurred:_____ _____

What are you asking for*:

Name of employer at time of injury*:

Business Mailing address of employer (main office)

Address*:_____

City*: State*: Zip*:

I desire to have any proceedings held in: (City) _____

(Signature of Preparer*)
Name*: (Please Print)
Phone*: (H) (W)
Social Security No:
Address*: _____ City*_____State:_____Zip:_____
It is important that the Board be able to reach you concerning your appeal. If you do not have a phone, please provide the number of a friend/relative where the Board can leave a message. Also, please notify the Board if you change your address.